PRINTED: 03/10/2022 FORM APPROVED OMB NO. 0938-0391

|  |  | A. BUILDIN   | IG   | CON   | (X3) DATE SURVEY<br>COMPLETED   |  |  |
|--|--|--|--|---|---|--|--|
|  | 345358   | B. WING _  |  |   | C<br><b>2/03/2022</b>   |  |  |
| /IDER OR SUPPLIER  |  | <u> </u>   | STREET ADDRESS, CITY, STATE, ZIP CODE  |   | 210312022   |  |  |
| HEALTHCARE & REH   | ABILITATION CENTER   |  | 202 SMOKETREE WAY<br>LOUISBURG, NC 27549   |   |   |  |  |
| (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL   | ID<br>PREFI)<br>TAG  | (EACH CORRECTIVE ACTION S  | SHOULD BE   | (X5)<br>COMPLETION<br>DATE  |  |  |
| NITIAL COMMENTS  |  | FC   | 00   |   |   |  |  |
|  |  |  |  |   |   |  |  |
| ubstantiated resulting   | g in deficiencies.   |  |  |   |   |  |  |
|  | •  | F 5  | 80   |   | 2/18/22   |  |  |
| A facility must immeronsult with the residence on sistent with his or learned to the presentative(s) where A) An accident involvesults in injury and has hysician intervention B) A significant changular charterioration in health that is in either life-thresinical complications) C) A need to alter treamed to discontinue eatment due to adverge ommence a new form D) A decision to transpectation of the facility when making notifications available and provide hysician.  If pertinent information is available and provide hysician.  If the facility must a desident and the resident there is-   | ediately inform the resident; ent's physician; and notify, ther authority, the resident in there ising the resident which as the potential for requiring gives in the resident's physical, all status (that is, a mental, or psychosocial eatening conditions or gratment significantly (that is, an existing form of rese consequences, or to an of treatment); or after or discharge the ty as specified in itication under paragraph (g) the facility must ensure that an specified in §483.15(c)(2) alled upon request to the less promptly notify the ent representative, if any,   |  |  |   |   |  |  |
| TO AM TO THE AMOST AND THE STREET OF A THE STREET AND THE STREET A | SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  STATEMAN AND STA (EACH DEFICIENCY REGULATORY OR LE  STATEMAN AND STA (EACH DEFICIENCY REGULATORY OR LE  STATEMAN AND STATEMAN (DOLLATORY OR LE  STATEMAN AND STATEMAN (DOLLATORY OR LE  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  STATEMAN AND STATEMAN (DOLLATORY OR LE  SUMMARY STA (DOLLATORY OR LE  STATEMAN AND STATEMAN (DOLLATORY OR LE  SUMMARY STA (DOLLATOR | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INTIAL COMMENTS  Complaint investigation was conducted from 02/22 through 2/03/22. Event ID# XPOC11  of the 10 complaint allegations were ubstantiated resulting in deficiencies. otify of Changes (Injury/Decline/Room, etc.)  FR(s): 483.10(g)(14)(i)-(iv)(15)  483.10(g)(14) Notification of Changes.  A facility must immediately inform the resident; possitent with his or her authority, the resident expresentative(s) when there is—  An accident involving the resident which expresentative(s) when there is—  A significant change in the resident's physical, ental, or psychosocial status (that is, a eterioration in health, mental, or psychosocial atus in either life-threatening conditions or inical complications);  A need to alter treatment significantly (that is, need to discontinue an existing form of eathment due to adverse consequences, or to commence a new form of treatment); or commence and the facility as specified in §483.15(c)(2) available and provided upon request to the hysician.  I) The facility must also promptly notify the sident and the resident representative, if any, | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  IITIAL COMMENTS  Complaint investigation was conducted from 02/22 through 2/03/22. Event ID# XPOC11  of the 10 complaint allegations were ubstantiated resulting in deficiencies. otify of Changes (Injury/Decline/Room, etc.) FR(s): 483.10(g)(14) Notification of Changes. A facility must immediately inform the resident; onsult with the resident's physician; and notify, onsistent with his or her authority, the resident presentative(s) when there is- A) An accident involving the resident which issults in injury and has the potential for requiring inscian intervention; A) A significant change in the resident's physical, ental, or psychosocial status (that is, a eterioration in health, mental, or psychosocial atus in either life-threatening conditions or inical complications); C) A need to alter treatment significantly (that is, need to discontinue an existing form of earmence a new form of treatment); or D) A decision to transfer or discharge the esident from the facility as specified in 183.15(c)(1)(ii).  When making notification under paragraph (g) 4)(i) of this section, the facility must ensure that I pertinent information specified in §483.15(c)(2) available and provided upon request to the hysician. I) The facility must also promptly notify the esident and the resident representative, if any, hen there is- A) A change in room or roommate assignment | HEALTHCARE & REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  JITIAL COMMENTS  Complaint investigation was conducted from 02/22 through 2/03/22. Event ID# XPOC11  of the 10 complaint allegations were ubstantiated resulting in deficiencies. Oitify of Changes (Injury/Decline/Room, etc.)  FF(s): 483.10(g)(14)(i)-(iv)(15)  483.10(g)(14)(i) of this or her authority, the resident synsitem with his or her authority, the resident presentative(s) when there is- 0) An accident involving the resident which sults in injury and has the potential for requiring sysician intervention; 2) A significant change in the resident's physical, ental, or psychosocial stus (that is, a sterioration in health, mental, or psychosocial atus in either life-threatening conditions or inical complications); 2) A need to alter treatment significantly (that is, need to discontinue an existing form of satment due to adverse consequences, or to commence a new form of treatment); or 0) A decision to transfer or discharge the sident from the facility as specified in 183.15(c)(1)(ii).  When making notification under paragraph (g) (4)(i) of this section, the facility must ensure that I pertinent information specified in §483.15(c)(2) available and provided upon request to the sysician.  I) The facility must also promptly notify the sident and the resident representative, if any, hen there is- | STREET ADDRESS, CITY, STATE, ZIP CODE 20 SMOKETREE WAY  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY) WIST SE PERCEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION)  ITTIAL COMMENTS  Complaint investigation was conducted from 02/22 through 2/03/22. Event ID# XPOC11  of the 10 complaint allegations were ubstantiated resulting in deficiencies.  In formal sequence (injury/Decline/Room, etc.)  FR(s): 483.10(g)(14) (i)-(iv)(15)  483.10(g)(14) Notification of Changes.  A facility must immediately inform the resident; noisult with the resident sphysician; and notify, noisistent with his or her authority, the resident presentative(s) when there is- (a) An accident involving the resident which sults in injury and has the potential for requiring syscian intervention; (b) A significant change in the resident's physical, ental, or psychosocial status (that is, a sterioration in health, mental, or psychosocial atus in either life-threatening conditions or inical complications); (c) A need to alter treatment significantly (that is, need to discontinue an existing form of satment due to adverse consequences, or to promence a new form of treatment); or (b) A decision to transfer or discharge the sident from the facility must ensure that I) pertinent information specified in §483.15(c)(2) available and provided upon request to the hysician. (1) The facility must also promptly notify the sident and the resident representative, if any, hen there is- (c) A change in room or roommate assignment |  |  |

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

02/17/2022

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

**Electronically Signed** 

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDII   |                     | IPLE CONSTRUCTION IG  | (X3) DATE SURVEY COMPLETED   |
|--|--|---|---------------------|---|--|
|  |  | 345358  | B. WING _           |   | 02/03/2022   |
|  | ROVIDER OR SUPPLIER  | HABILITATION CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549   | OLIOO/2022   |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENCE   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)   | ULD BE COMPLETION  |
| F 580  | State law or regulation (e)(10) of this section (iv) The facility must update the address of phone number of the representative(s).  §483.10(g)(15) Admission to a computate is a composite of §483.5) must disclose its physical configurational configurational configurational configurational configurational configurational composite of §483.5) must disclose its physical configurational configuration configurational configuration configurational configuration config | dent rights under Federal or cons as specified in paragraph on.  record and periodically (mailing and email) and eresident  cosite distinct part. A facility distinct part (as defined in see in its admission agreement ation, including the various isee the composite distinct for the policies that apply to be its different locations.  To is not met as evidenced view, staff and Physician failed to notify the Physician of that was not provided for 1 and #1) reviewed for enteral endmitted to the facility on a diagnoses that included and 9-13-21 revealed an order ceive enteral feeding at 60cc er hour from 6:00pm to | F 5                 | The statements made on this plan correction are not an admission to not constitute an agreement with talleged deficiencies.  To remain in compliance with all fe and state regulations the facility hor will take the actions set forth in plan of correction. The plan of corconstitutes the facility allegation compliance such that all alleged deficiencies cited have been or with corrected by the dates indicated. F 580  The plan of correcting the specific deficiency. The plan should addresprocesses that lead to the deficiencited:  The facility failed to notify the physical entertal tube feeding that was not according to the specific deficiency. | e and do the ederal as taken this rection n of II be ess the acy sician of |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|---|--|---|-------------------------------|--|
|   |  | 345358  | B. WING                                 |  |   | C                             |  |
| NAME OF D   | ROVIDER OR SUPPLIER  | 343330  | B: Wii(0                                | STREET ADDRESS, CITY, STATE, ZIP CODI  | •   | 2/03/2022                     |  |
| NAME OF PI  | ROVIDER OR SUPPLIER  |   |   | , , ,  | E   |                               |  |
| LOUISBUI  | RG HEALTHCARE & RE   | HABILITATION CENTER   |   | 202 SMOKETREE WAY  |   |                               |  |
|   |  | -   |   | LOUISBURG, NC 27549  |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)  | SHOULD BE   | (X5)<br>COMPLETION<br>DATE    |  |
| F 580   | Continued From pag   | ge 2  | F 58                                    | 30   |   |                               |  |
|   |  | entation that Resident #1<br>feeding on 1-27-22 through   |   | administered to resident #1.  1. Corrective action for resident affected by the alleged deficience Resident # 1 was sent to the experience.  | nt practice:  |                               |  |
|   | During a telephone interview with Resident #1 on 2-2-22 at 11:28am, Resident #1 discussed his return to the facility from the hospital on 1-27-22 in the afternoon. The resident stated he was not provided his tube feeding at 6:00pm on 1-27-22 through 10:00am on 1-28-22.  Nurse #3 was interviewed on 2-2-22 at 3:45pm. Nurse #3 acknowledged he was assigned to care for Resident #1 on 1-27-22 during the 3:00pm to 11:00pm shift. The nurse stated he did not provide Resident #1 with his enteral feeding at 6:00pm. The nurse stated he did not contact the Physician to inform him that Resident #1's enteral feeding had not been provided.  Nurse #4 was interviewed by telephone on 2-3-22 at 7:08am. The nurse acknowledged she was assigned to care for Resident #1 on the night shift (11:00pm to 7:00am) on 1-27-22. She explained she did not investigate why Resident #1 did not have his enteral feeding and she stated she had not informed the Physician that Resident #1 had not received his enteral feeding. |   |   | room on 1/28/ 2022 and admir hospital.  2. Corrective action for residence the potential to be affected by deficient practice.  All residents with ordered entertails.   | tted to the dents with the alleged                                      |                               |  |
|   |  |   |   | feeding have the potential to be by the alleged deficient practic On 02/04/2022, the Director of Support Nurse (LPN) initiated 100% of all residents with ordetube feedings for the last 14 denotification of the physician of feeding that had not been admitted. | ce.  f Nurses, an audit of ered enteral ays for any enteral ninistered. |                               |  |
|   |  |   |   | 3. Measures /Systemic char prevent reoccurrence of allege practice: On 2/03/2022 the Director of Negan education of all full time as needed nurses and agency on the following topics: Medication errors and notifical physician/RP.                               | ed deficient  Nurses e, part time, / nurses and                         |                               |  |
|   | telephone on 2-2-22<br>discussed not being<br>received his enteral<br>facility from the hosp<br>would have expecte   | n was interviewed by at 5:30pm. The Physician aware Resident #1 had not feeding upon his return to the bital on 1-27-22. He stated he d staff to contact him and dent #1 had not received his |   | physician/RP. Documentation process for not the physician/RP.  On 2/07/2022 the Director of Notes that the physician of all full time as needed nurses and agency on the following topics: Facility policy on resident charcondition.                              | Nurses<br>e, part time,<br>/ nurses and                                 |                               |  |
|   | The Administrator w  | as interviewed on 2-3-22 at   |   | Continual nursing care to inclu  | ıde any   |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | IDENTIFICATION NUMBER:   |                     | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |  |   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|---------------------|--|--|---|-------------------------------|--|
|   |   | 345358   | B. WING _           |  |  | 02/   | 03/2022                       |  |
| NAME OF P   | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS   | S, CITY, STATE, ZIP CODE   | 1 02/1  | 03/2022                       |  |
|   |   |  |                     | 202 SMOKETRE   |  |   |                               |  |
| LOUISBU   | RG HEALTHCARE & RE  | EHABILITATION CENTER   |                     | LOUISBURG, N   | NC 27549   |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)                                   | ID<br>PREFIX<br>TAG | (EAC   | ROVIDER'S PLAN OF CORRECTION<br>CH CORRECTIVE ACTION SHOULD B<br>S-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  |   | (X5)<br>COMPLETION<br>DATE    |  |
| F 580   | #1's enteral feeding<br>unaware he had not<br>1-27-22. She stated | istrator discussed Resident was available and was received his feeding on she would have expected ysician when Resident #1's | F5                  | The DON value above ider complete to 2/18/2022 the training will be incompleted and/or in completed and/or in completing monthly xalue and the notification with the fact residents value and the on reviewed a Meeting. Tattended b Nursing, Mandows in the poly Mercan and the on reviewed a Meeting. Tattended b Nursing, Mandows in the result of the poly month in the fact residents value and the on reviewed a meeting. Tattended b Nursing, Mandows in the poly meeting in the poly meeting in the poly meeting. Tattended b Nursing, Mandows in the poly meeting in the poly | will ensure that any of the ntified staff who does not the in-service training by will not be allowed to work urg is completed. This in-service training Procedure to ensure the facility orientation.  Toring Procedure to ensure the facility orientation or procedure to ensure the facility orientation.  Toring Procedure to ensure the facility or or or pliance will in the weekly x 4 then and the process by auditing the process by auditing Daileday-Friday) for compliance was another or or or or compliance or | at nat cted  t the  The ly with  a ce  y  ored  nce  r of or, |                               |  |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL <sup>-</sup><br>A. BUILDI |            | CONSTRUCTION   | (X3) DATE<br>COMP          | SURVEY<br>LETED            |
|--------------------------|--|--|------------------------------------|------------|--|----------------------------|----------------------------|
|                          |  | 0.45050  |                                    | _          |  |                            | c                          |
|                          |  | 345358   | B. WING                            |            |  | 02/                        | 03/2022                    |
|                          | ROVIDER OR SUPPLIER  | HABILITATION CENTER  |                                    | 20         | TREET ADDRESS, CITY, STATE, ZIP CODE  22 SMOKETREE WAY  OUISBURG, NC 27549   |                            |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                 |            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |                            | (X5)<br>COMPLETION<br>DATE |
| F 580                    | Continued From pag  Quality of Care  | e 4  |                                    | 580<br>684 | Manager.   |                            | 2/18/22                    |
| SS=D                     | applies to all treatmet facility residents. Bas assessment of a resithat residents received accordance with profipractice, the compressore plan, and the restriction of the resident practice, the compressore plan, and the restriction of the resident profit o | Indamental principle that int and care provided to sed on the comprehensive dent, the facility must ensure extreatment and care in sessional standards of thensive person-centered sidents' choices.  To is not met as evidenced riew, resident, staff, and the facility failed to perform an and on a resident being hospital with multiple tracheostomy, dependence enteral feedings, indwelling for COVID-19. This issident (Resident #1) ments.  Admitted to the facility on diagnoses that included estomy, dependence on the covidence of the covidence on the covidence of the c |                                    |            | The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies.  To remain in compliance with all federa and state regulations the facility has take or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.  F 684  The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:  The facility failed to clarify physician orders for oxygen and failed to perform admission assessment for resident # 1 who was being readmitted to the facility 1. Corrective action for resident(s) affected by the alleged deficient practice. | il<br>Ken<br>on<br>e<br>an |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | IDENTIFICATION NUMBER:                                     |              |     | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                    |
|---|--|--|--------------|-----|---|-------------------------------|--------------------|
|   |  |  |              |     |   |                               |                    |
|   |  | 345358   | B. WING _    |     |   | 02/                           | 03/2022            |
| NAME OF PR  | ROVIDER OR SUPPLIER                            |  |              | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                    |
|   |  |  |              | 20  | 02 SMOKETREE WAY  |                               |                    |
| LOUISBUR  | RG HEALTHCARE & REI                            | HABILITATION CENTER  |              | L   | OUISBURG, NC 27549  |                               |                    |
| (X4) ID   | SUMMARY ST                                     | ATEMENT OF DEFICIENCIES                                    | ID           |     | PROVIDER'S PLAN OF CORRECTION   |                               | (X5)               |
| PRÉFIX<br>TAG                                       | ,  | Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION) | PREFI<br>TAG | X   | (EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)       |                               | COMPLETION<br>DATE |
| F 684   | Continued From page                            | e 5  | F            | 684 |   |                               |                    |
|   | 2-2-22 at 11:28am, th                          | e resident discussed                                       |              |     | Resident # 1 was sent to the emergence  | y                             |                    |
|   | returning to the facility from the hospital on |  |              |     | room on 1/28/ 2022 and admitted to the  | •                             |                    |
|   | 1-27-22 during the aft                         | ternoon. He stated he was                                  |              |     | hospital.   |                               |                    |
|   | placed in a resident re                        | oom and no staff had                                       |              |     | <ol><li>Corrective action for residents with</li></ol>                                      | ı                             |                    |
|   |  | s, trach, catheter, or his peg                             |              |     | the potential to be affected by the alleg   | ed                            |                    |
|   |  | edings. Resident #1 said he                                |              |     | deficient practice.   |                               |                    |
|   |  | (Nurse #3) about checking                                  |              |     | All residents being admitted or readmit   |                               |                    |
|   |  | catheter and peg tube and                                  |              |     | have the potential to be affected by the  |                               |                    |
|   |  | old him the previous nurse                                 |              |     | alleged deficient practice.   |                               |                    |
|   | (Nurse #1) had alread                          | dy assessed him.   |              |     | On 02/03/2022, the Director of Nurses,  |                               |                    |
|   |  |  |              |     | Support Nurse (LPN) completed an aud  |                               |                    |
|   |  | se #1 occurred on 2-2-22 at                                |              |     | of 100% of admission/readmissions for   |                               |                    |
|   | 12:20pm. Nurse #1 co                           |  |              |     | the last 14 days for completion of  |                               |                    |
|   |  | esident #1 on the 7:00am to                                |              |     | admission/readmission assessments a   | nd                            |                    |
|   |  | 22. She stated she did                                     |              |     | admission orders utilizing the facility   |                               |                    |
|   |  | on assessment on Resident                                  |              |     | Admission and Readmission Checklist.  | _                             |                    |
|   |  | ssed his tracheostomy,                                     |              |     | There were no other concerns identified   | J.                            |                    |
|   |  | us, peg tube, or retrieved a                               |              |     | 2 Magauras (Systemia shangas ta   |                               |                    |
|   |  | se #1 said she believed the as going to complete the       |              |     | <ol><li>Measures /Systemic changes to<br/>prevent reoccurrence of alleged deficie</li></ol> | nt                            |                    |
|   | admission assessmen                            |  |              |     | practice:   | 111                           |                    |
|   |  |  |              |     | On 02/02/2022 the Director of Nurses a  |                               |                    |
|   | The Wound Care nurs                            |  |              |     | Support Nurse (LPN) were retrained or   |                               |                    |
|   |  | 2 at 12:27pm. Nurse #2                                     |              |     | the admission/readmission daily clinica   | I                             |                    |
|   | <del>_</del>                                   | Resident #1's wounds with                                  |              |     | process by the QA Nurse Consultant.   |                               |                    |
|   | •  | ician on 1-27-22 at 4:00pm.                                |              |     | On 2/03/2022 the Director of Nurses   |                               |                    |
|   |  | nformed Nurse #1 she would                                 |              |     | began education of all full time, part tim  |                               |                    |
|   | •  | sessment section of the                                    |              |     | as needed nurses and agency nurses a  | and                           |                    |
|   |  | nt but had not said she                                    |              |     | on the following topics:  |                               |                    |
|   | would complete the w                           |  |              |     | The admission/readmission process   |                               |                    |
|   |  | 2 confirmed she did not signs, assess the resident's       |              |     | Admission/Readmission orders and reconciliation   |                               |                    |
|   |  | catheter, or peg tube while                                |              |     | Review of all discharge documentation   | for                           |                    |
|   | she was assessing hi                           |  |              |     | _   | IUI                           |                    |
|   | one was assessing III                          | s woulius.   |              |     | order accuracy. Review of any additional documents  |                               |                    |
|   | Nursing Assistant (NI)                         | A) #3 was interviewed on                                   |              |     | received to reconcile any new or chang  | led                           |                    |
|   |  | x) #3 was interviewed on x #3 confirmed she was the        |              |     | orders.   | cu                            |                    |
|   |  | lent #1 on 1-27-22 for the                                 |              |     | Completion admit/readmit UDA and  |                               |                    |
|   | 3:00pm to 11:00pm s                            |  |              |     | nursing documentation.  |                               |                    |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|----------------------|---|--------------------|---|--|-------------------------------|----------------------------|
|   |                      | 345358  | B. WING            |   |  | 1                             | C                          |
| NAME OF D   | DOV/IDED OD OUDDUIED | 34330   | B. WING _          |   | OTREET ADDRESS SITV STATE 7/D SODE   | 02                            | /03/2022                   |
| NAME OF P   | ROVIDER OR SUPPLIER  |   |                    |   | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                            |
| LOUISBU   | RG HEALTHCARE & RI   | EHABILITATION CENTER  |                    |   | 202 SMOKETREE WAY  |                               |                            |
|   |                      |   |                    | L                                       | LOUISBURG, NC 27549  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIEN       | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG |   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 684   | Continued From pag   | ge 6  | F                  | 684                                     |  |                               |                            |
|   |                      | #1 2 times during her shift but   |                    |   | The DON will ensure that any of the  |                               |                            |
|   |                      | btain a set of vital signs or   |                    |   | above identified staff who does not  |                               |                            |
|   | observe his cathete  |   |                    |   | complete the in-service training by  |                               |                            |
|   |                      | 7.5   |                    |   | 2/18/2022 will not be allowed to work u  | ıntil                         |                            |
|   | During an interview  | with Nurse #3 on 2-2-22 at  |                    |   | the training is completed. This in-service   | се                            |                            |
|   |                      | onfirmed he was assigned to   |                    |   | will be incorporated into the new  |                               |                            |
|   |                      | 7-22 during the 3:00pm to   |                    |   | employee facility orientation.   |                               |                            |
|   |                      | so confirmed he had not   |                    |   |  |                               |                            |
|   | completed an admis   |   |                    |   |  |                               |                            |
|   |                      | d he believed the nurse from  |                    |   | 4. Monitoring Procedure to ensure th   |                               |                            |
|   | completed the asset  | om shift (Nurse #1) had   |                    |   | the plan of correction iseffective and the specific deficiency cited remains corrections.                            |                               |                            |
|   |                      | id not obtain a set of vital  |                    |   | and/or in compliance with regulatory   | Jieu                          |                            |
|   |                      | sident #1's trach, catheter,  |                    |   | requirements.  |                               |                            |
|   |                      | status during his shift.  |                    |   | The Director of Nurses or LPN Suppor   | t                             |                            |
|   |                      |   |                    |   | Nurse will monitor compliance utilizing  |                               |                            |
|   | Nurse #4 was interv  | riewed by telephone on 2-3-22   |                    |   | F684 Quality Assurance Tool by   |                               |                            |
|   | at 7:08am. Nurse #4  | 1 confirmed she was assigned  |                    |   | completing an audit weekly x 4 then  |                               |                            |
|   | to Resident #1 on th | ne 11:00pm to 7:00am shift for  |                    |   | monthly x 3 months or until resolved. T  | he                            |                            |
|   |                      | llso confirmed she did  |                    |   | audit will include monitoring of   |                               |                            |
|   |                      | sion assessment on Resident   |                    |   | admit/readmit assessments and admitt   | ing                           |                            |
|   | I .                  | "I thought the previous nurses  |                    |   | orders utilizing the facility  |                               |                            |
|   | I .                  | dmitted during day shift  |                    |   | Admission/Readmission Checklist Aud  | it                            |                            |
|   | (7:00am to 3:00pm)   |   |                    |   | Tool for compliance. Reports will be presented to the Quality Assurance  |                               |                            |
|   | Δ telenhone intervie | w was conducted on 2-2-22 at  |                    |   | Committee by the Administrator or  |                               |                            |
|   | 1                    | ility's Physician. The  |                    |   | Director of Nurses to ensure corrective  | 1                             |                            |
|   |                      | d Resident #1 being a   |                    |   | action is initiated as appropriate.  |                               |                            |
|   | 1                    | le stated he would have   |                    |   | Compliance will be monitored and the   |                               |                            |
|   |                      | rform a complete assessment   |                    |   | ongoing auditing program reviewed at   | the                           |                            |
|   | of Resident #1's nee | · · · · · · · · · · · · · · · · · · ·   |                    |   | weekly Quality Assurance Meeting. Th   |                               |                            |
|   |                      |   |                    |   | weekly QA Meeting is attended by the   |                               |                            |
|   |                      | as interviewed on 2-3-22 at   |                    |   | Administrator, Director of Nursing,  |                               |                            |
|   | · •                  | istrator stated her staff were  |                    |   | Minimum Data Set Coordinator, Thera  |                               |                            |
|   | I .                  | g admission assessments on  |                    |   | Manager, Health Information Manager  | ,                             |                            |
|   |                      | residents and did not know  |                    |   | Support Nurse and Dietary Manager.   |                               |                            |
|   | why an admission a   |   |                    |   |  |                               |                            |
|   | completed for Resid  | ient #1.  |                    |   | The Director of Nurses or LDN Commen   | <b>+</b>                      |                            |
|   | 1                    |   | 1                  |   | The Director of Nurses or LPN Suppor   | L                             | 1                          |

|                          | TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING   |  |                    | (X3) DATE SURVEY<br>COMPLETED |  |                   |                            |
|--------------------------|---|--|--------------------|-------------------------------|--|-------------------|----------------------------|
|                          |   | 345358   | B. WING            |                               |  |                   | C<br>03/2022               |
|                          | ROVIDER OR SUPPLIER   | HABILITATION CENTER  | 1                  | 20                            | TREET ADDRESS, CITY, STATE, ZIP CODE<br>12 SMOKETREE WAY<br>DUISBURG, NC 27549   |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |                   | (X5)<br>COMPLETION<br>DATE |
| F 693<br>SS=D            | S483.25(g)(4)-(5) Ent (Includes naso-gastric both percutaneous er percutaneous endosc enteral fluids). Based comprehensive assessensure that a resident s483.25(g)(4) A reside at enough alone or venteral methods unle condition demonstrate clinically indicated an resident; and \$483.25(g)(5) A residents receives the assessment of the second secon | Restore Eating Skills (5) eral Nutrition c and gastrostomy tubes, ndoscopic gastrostomy and copic jejunostomy, and on a resident's esment, the facility must |                    | 684                           | Nurse will monitor compliance by completing 4 random trach care observation audits weekly x 4 then monthly x 3 months or until resolved. Reports will be presented to the Quality Assurance Committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monito and the ongoing auditing program reviewed at the weekly Quality Assurar Meeting. The weekly QA Meeting is attended by the Administrator, Director Nursing, Minimum Data Set Coordinate Therapy Manager, Health Information Manager, Support Nurse and the Dieta Manager. | ored<br>of<br>or, | 2/18/22                    |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | I DENTIFICATION NUMBER:  |                     |     | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|--|---------------------|-----|---|-------------------------------|----------------------------|
|  |   | 345358   | B. WING _           |     |   | l                             | 03/2022                    |
| NAME OF P  | ROVIDER OR SUPPLIER   |  |                     | ST  | REET ADDRESS, CITY, STATE, ZIP CODE   | 1 02/                         | 03/2022                    |
|  |   |  |                     |     | 2 SMOKETREE WAY   |                               |                            |
| LOUISBUI   | RG HEALTHCARE & REI   | HABILITATION CENTER  |                     |     | DUISBURG, NC 27549  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |                               | (X5)<br>COMPLETION<br>DATE |
| F 693  | Continued From page   | e 8  | F 6                 | 593 |   |                               |                            |
| F 693  | and to prevent complincluding but not limit diarrhea, vomiting, de abnormalities, and na This REQUIREMENT by: Based on record rev physician interview, the enteral feeding as predicted (Resident #1) reviewed Findings included Resident #1 was real 1-27-22 with multiple tracheostomy Physician order dated for Resident #1 to redicted feeding at 60cc (cubic 6:00pm to 10:00am of the enteral feeding at 60cc (cubic 6:00pm to 10:00am of the goal that he would resymptoms of fluid over the goal were in part ordered, administer with the symptoms of fluid over the goal were in part ordered, administer with the symptoms of fluid over the goal were in part ordered, administer with the symptoms of fluid over the goal were in part ordered, administer with the symptoms of fluid over the goal were in part ordered, administer with the symptoms of fluid over the goal were in part ordered, administer with the symptoms of fluid over the goal were in part ordered, administer with the symptoms of fluid over the goal were in part ordered, administer with the symptoms of fluid over the goal were in part ordered, administer with the symptoms of fluid over the goal were in part ordered, administer with the symptoms of fluid over the goal were in part ordered. | ications of enteral feeding ed to aspiration pneumonia, ehydration, metabolic asal-pharyngeal ulcers.  is not met as evidenced iew, resident, staff and he facility failed to administer escribed for 1 of 1 resident ed for tube feeding.  Idmitted to the facility on diagnoses that included  d 9-13-21 revealed an order ceive enteral feeding enteral c centimeter) per hour from | F                   | 693 | The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies.  To remain in compliance with all federa and state regulations the facility has tall or will take the actions set forth in this plan of correction. The plan of correctic constitutes the facility sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 693  The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:  The facility failed to administer ordered enteral tube feeding for resident # 1.  1. Corrective action for resident(s) affected by the alleged deficient practic Resident # 1 was sent to the emergency on 1/28/2022 and admitted to the hospital.  2. Corrective action for residents with the potential to be affected by the alleged deficient practice. | e<br>e<br>ece:<br>ecy<br>e    |                            |
|  | 11-12-21 revealed Reintact and was coded  | esident #1 was cognitively<br>for tube feeding and<br>re calories from his tube  |                     |     | deficient practice.  All residents with ordered enteral tube feeding have the potential to be affected by the alleged deficient practice. On 02/03/2022, the Director of Nurses, Support Nurse (LPN) initiated an audit the last 14 days of 100% of residents were supported.   | for                           |                            |

| STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION |  | IDENTIFICATION NUMBER:  |                     | ) MULTIPLE CONSTRUCTION BUILDING |  |                                      | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|---|---------------------|----------------------------------|--|--------------------------------------|-------------------------------|--|
|  |  | 245250  | B. WING             |                                  |  |                                      | С                             |  |
|  |  | 345358  | B. WING_            |                                  |  | 02/                                  | 03/2022                       |  |
| NAME OF PI   | ROVIDER OR SUPPLIER  |   |                     |                                  | TREET ADDRESS, CITY, STATE, ZIP CODE   |                                      |                               |  |
| LOUISBUI   | RG HEALTHCARE & REI  | HABILITATION CENTER   |                     | 2                                | 02 SMOKETREE WAY   |                                      |                               |  |
| 200.020.   |  |   |                     | L                                | OUISBURG, NC 27549   |                                      |                               |  |
| (X4) ID<br>PREFIX<br>TAG                             | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | X                                | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  |                                      | (X5)<br>COMPLETION<br>DATE    |  |
| F 693  | Continued From page  | e 9   | F 6                 | 693                              |  |                                      |                               |  |
|  | revealed no documer  | d (MAR) for January 2022<br>ntation that Resident #1<br>eeding on 1-27-22 through   |                     |                                  | enteral tube feeding orders for administration of tube feeding as order No other concerns identified.  | ed.                                  |                               |  |
|  | During a telephone in 2-2-22 at 11:28am, R return to the facility fr in the afternoon. The provided his tube feereceive at 6:00pm on on 1-28-22. The reside soup on the evening not receive any food had questioned Nurse receiving his tube feetold him he was check said he questioned N did not know. Reside upset on 1-28-22 that questions.  Nurse #3 was intervied Nurse #3 acknowledge for Resident #1 on 1-11:00pm shift. The nuprovide Resident #1 or provide Resident #1 or 1-11:00pm shift. | atterview with Resident #1 on esident #1 discussed his om the hospital on 1-27-22 resident stated he was not ding he was supposed to 1-27-22 through 10:00am dent discussed eating some of 1-27-22 but stated he did on 1-28-22. He explained he e #3 why he was not riding and stated the nurse king for an order, and he urse #4 who told him she int #1 discussed feeling the did not ask any more exwed on 2-2-22 at 3:45pm. Gred he was assigned to care 27-22 during the 3:00pm to urse stated he did not with his enteral feeding at the could not find Resident |                     |                                  | 3. Measures /Systemic changes to prevent reoccurrence of alleged deficie practice: On 2/03/2022 the Director of Nurses began education of all full time, part tin as needed nurses and agency nurses the following topics: Med error prevention to include medication/treatment administration/documentation and notification/documentation of MD/RP orefusals or meds/tx□s/oxygen or enterfeedings not administered. The DON will ensure that any of the above identified staff who does not complete the in-service training by 2/18/2022 will not be allowed to work ut the training is completed. This in-service will be incorporated into the new employee facility orientation.  4. Monitoring Procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory | ne,<br>on<br>if<br>al<br>intil<br>ce |                               |  |
|  | #1's enteral feeding uexplained the resident several different place locate the medication nurse stated he did nurse stated he did nurse stated the Provided in the Provided.  | ıntil the end of his shift. He  |                     |                                  | requirements. The Director of Nurses or LPN Suppor Nurse will monitor compliance utilizing F693 Quality Assurance Tool by completing an audit weekly x 4 then monthly x 3 months or until resolved. Taudit will include monitoring of enteral tube feeding administration to assure it being provided as ordered. Reports w be presented to the Quality Assurance Committee by the Administrator or  | the<br>he<br>t is                    |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED            |                            |
|--|---|---|---|---|--|----------------------------|
|  |   | 345358  | B. WING                                 |   |  | C<br>/ <b>03/2022</b>      |
|  | ROVIDER OR SUPPLIER   | L   |   | STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549   | 02                                       | 0312022                    |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRICENCY)   | ULD BE                                   | (X5)<br>COMPLETION<br>DATE |
| F 693  | assigned to care for F (11:00pm to 7:00am) she was aware Residenteral feedings durin had observed there whanging. She explain why Resident #1 did and she stated, "I tho to have it (enteral fee would have hung it." I had not received a reprevious nurse (Nurse During an interview who 12:20pm, Nurse #1 and assigned to care for F during the 7:00am to stated she had not not have his enteral feeding provided him with his 1-28-22.  The facility Physician telephone on 2-2-22 and discussed Resident #1 foods by mouth but moutrition was provided stated he would have Resident #1 with his what time during the foods by mouth but moutrition was provided stated he would have Resident #1 with his what time during the foods by mouth but moutrition was provided stated he would have Resident #1 with his what time during the foods.  The Administrator was 1:20pm. The Adminis #1's enteral feeding woundware he had not resident #1 with his foods. | Resident #1 on the night shift on 1-27-22. Nurse #4 stated ent #1 was to receive ag the night and said she was no enteral feeding ed she did not investigate not have his enteral feeding ught if he (the resident) was ding) the previous nurse Nurse #4 acknowledged she port on Resident #1 from the e #3).  With Nurse #1 on 2-2-22 at cknowledged she was Resident #1 on 1-28-22 3:00pm shift. The nurse officed Resident #1 did not ang hanging when she medications at 9:00am on  Was interviewed by at 5:30pm. The Physician end being able to eat some most of the resident's did by his enteral feedings. He expected staff to provide enteral feeding no matter evening the feeding was secived his feeding on She stated she expected her | F 69                                    | Director of Nurses to ensure correaction is initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewe weekly Quality Assurance Meeting weekly QA Meeting is attended by Administrator, Director of Nursing Minimum Data Set Coordinator, T Manager, Health Information Man Support Nurse and the Dietary Ma | the d at the g. The the the herapy ager, |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | PLE CONSTRUCTION  G  |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---------------------|--|--|-------------------------------|--|
|   |  | 345358   | B. WING _           |  |  | C<br>02/03/2022               |  |
|   | ROVIDER OR SUPPLIER  | REHABILITATION CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP COD<br>202 SMOKETREE WAY<br>LOUISBURG, NC 27549   | •  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>DR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)  | I SHOULD BE  | (X5)<br>COMPLETION<br>DATE    |  |
| F 695<br>SS=D                                       | S 483.25(i) Respiratracheostomy care The facility must eneeds respiratory care and tracheal scare, consistent wipractice, the comporare plan, the resident 483.65 of this This REQUIREMED by:  Based on record rephysician interview Physician interview Physician orders for provide tracheostomy provide tracheostomy in the place revealed a gwould remain pate optimal oxygenatic goal were in participal ordered, trach care The quarterly Mining 11-12-21 revealed | eview, resident, staff and the facility failed to clarify or oxygen therapy and failed to my care as ordered by the I resident (Resident #1) | F6                  | The statements made on this correction are not an admission not constitute an agreement walleged deficiencies.  To remain in compliance with and state regulations the facilior will take the actions set for plan of correction. The plan of constitutes the facility's allegar compliance such that all allegateficiencies cited have been accorrected by the dates indicated for the plan of correcting the specific ciency. The plan should accorrected by the dates indicated for the facility failed to clarify phyorders for oxygen and failed to ordered tracheostomy care for the facility failed to clarify phyorders for oxygen and failed to ordered tracheostomy care for the facility failed to clarify phyorders for oxygen and failed to ordered tracheostomy care for the facility failed to clarify phyorders for oxygen and failed to ordered tracheostomy care for the facility failed to clarify phyorders for oxygen and failed to ordered tracheostomy care for the facility failed to clarify phyorders for oxygen and failed to ordered tracheostomy care for the facility failed to clarify phyorders for oxygen and failed to ordered tracheostomy care for the facility failed to clarify phyorders for oxygen and failed to ordered tracheostomy care for the facility failed to clarify phyorders for oxygen and failed to ordered tracheostomy care for the facility failed to clarify phyorders for oxygen and failed to ordered tracheostomy care for the facility failed to clarify phyorders for oxygen and failed to ordered tracheostomy care for the facility failed to clarify phyorders for oxygen and failed to ordered tracheostomy care for the facility failed to clarify phyorders for oxygen and failed to ordered tracheostomy care for the facility failed to clarify phyorders for oxygen and failed to ordered tracheostomy care for the facility failed to clarify phyorders for oxygen and fai | all federal ity has taken the in this f correction ation of eed or will be teed.  ecific ddress the ficiency ysician o provide or resident # dent(s) ent practice: emergency | 2/25/22                       |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | IDENTIFICATION NUMBER:   |                     | MULTIPLE CONSTRUCTION  JILDING |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|---------------------|--------------------------------|---|-------------------------------|----------------------------|
|   |  | 345358   | B. WING             |                                |   |                               | C<br>03/2022               |
| NAME OF PE  | ROVIDER OR SUPPLIER                                |  |                     | S                              | TREET ADDRESS, CITY, STATE, ZIP CODE  | 1 02/                         | 03/2022                    |
|   |  |  |                     |                                | 02 SMOKETREE WAY  |                               |                            |
| LOUISBUR  | RG HEALTHCARE & F                                  | REHABILITATION CENTER  |                     |                                | OUISBURG, NC 27549  |                               |                            |
|   | OLIMANA DV   | OTATEMENT OF REFIGIENCIES  |                     |                                |   |                               | 0.17)                      |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIE                                      | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID<br>PREFII<br>TAG | X                              | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 695   | Continued From pa                                  | age 12   | F                   | 395                            |   |                               |                            |
|   | Review of discharg                                 | je hospital record dated   |                     |                                | 2. Corrective action for residents with   | า                             |                            |
|   |  | Physician orders to continue   |                     |                                | the potential to be affected by the alleg   | jed                           |                            |
|   | oxygen therapy.                                    |  |                     |                                | deficient practice.   |                               |                            |
|   |  |  |                     |                                | All residents with ordered oxygen or  |                               |                            |
|   | Resident #1's phys                                 | sician order for January 2022  |                     |                                | residents with a tracheostomy have the  | <b>.</b>                      |                            |
|   | was reviewed and                                   | revealed documentation that  |                     |                                | potential to be affected by the alleged   |                               |                            |
|   | Resident #1 had be                                 | een on 4 liters of oxygen prior  |                     |                                | deficient practice.   |                               |                            |
|   | to his hospitalization                             | on on 1-19-22.   |                     |                                | On 02/04/2022, the Director of Nurses   | ,                             |                            |
|   |  |  |                     |                                | Support Nurse (LPN) initiated an audit  |                               |                            |
|   | During an interview with Nurse #1 on 2-2-22 at     |  |                     |                                | 100% of admission/readmissions and  | of                            |                            |
|   |  | e acknowledged she was the   |                     |                                | those residents receiving oxygen to   |                               |                            |
|   | _  | Resident #1 on 1-27-22. She  |                     |                                | assure physician orders are in place a  | nd                            |                            |
|   | discussed not completing Resident #1's             |  |                     |                                | that residents are receiving oxygen as  |                               |                            |
|   | admission assessment or processing the             |  |                     |                                | ordered with no other identified concer   | ns                            |                            |
|   | resident's orders from the hospital so she had not |  |                     |                                | noted On 2/04/2022 the Director of  |                               |                            |
|   |  | the number of liters of oxygen   |                     |                                | Nurses, Support Nurse audited all curr  |                               |                            |
|   | Resident #1 was to                                 | receive.   |                     |                                | residents with a tracheostomy to assur  |                               |                            |
|   | Numaa #2 uuaa intan                                | ninwad on 2.2.22 at 2.45 and   |                     |                                | tracheostomy care was being provided  |                               |                            |
|   |  | viewed on 2-2-22 at 3:45pm.<br>edged he was assigned to care                           |                     |                                | ordered. There were no other concernsidentified for oxygen or tracheostomy                                  | 5                             |                            |
|   |  | the 3:00pm to 11:00pm shift  |                     |                                | care.   |                               |                            |
|   |  | urse stated he had not   |                     |                                | Care.   |                               |                            |
|   |  | t #1's oxygen liters or called   |                     |                                | 3. Measures /Systemic changes to  |                               |                            |
|   |  | fy the Physician order on the  |                     |                                | prevent reoccurrence of alleged deficie   | nt                            |                            |
|   |  | oxygen Resident #1 was to  |                     |                                | practice:   |                               |                            |
|   |  | he thought the resident was to   |                     |                                | On 2/03/2022 the Director of Nurses   |                               |                            |
|   | receive 3 liters of c                              |  |                     |                                | began education of all full time, part tin  | ne.                           |                            |
|   |  | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,  |                     |                                | as needed nurses and agency nurses  |                               |                            |
|   | The facility's Physi                               | cian was interviewed by  |                     |                                | med aides on the following topics:  |                               |                            |
|   |  | 2 at 5:30pm. The Physician   |                     |                                | The admission/readmission process   |                               |                            |
|   | •  | t #1 being high risk and he  |                     |                                | Admission/Readmission orders and  |                               |                            |
|   |  | ed staff to call the hospital and  |                     |                                | reconciliation  |                               |                            |
|   | clarify the oxygen                                 | orders. He also stated he would  |                     |                                | Review of all discharge documentation   | for                           |                            |
|   | •  | staff to place Resident #1   |                     |                                | order accuracy.   |                               |                            |
|   |  | f oxygen he received prior to  |                     |                                | Review of any additional documents  |                               |                            |
|   | his hospitalization                                | which was 4 liters.  |                     |                                | received to reconcile any new or chang  | ged                           |                            |
|   |  |  |                     |                                | orders.   |                               |                            |
|   |  | ty's Physician order dated   |                     |                                | Completion admit/readmit UDA and  |                               |                            |
|   | 1-11-22 revealed a                                 | n order for Resident #1 to   |                     |                                | nursing documentation.  |                               |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                | ` ′                 | X2) MULTIPLE CONSTRUCTION  A. BUILDING  |  |       | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|---------------------|---|--|-------|-------------------------------|--|
|   |  | 345358  | B. WING _           |   |  |       | C<br><b>03/2022</b>           |  |
| NAME OF PR  | ROVIDER OR SUPPLIER                              | <u> </u>  | <del>-</del>        |   | STREET ADDRESS, CITY, STATE, ZIP CODE  | 1 02/ | 03/2022                       |  |
|   |  |   |                     |   | 202 SMOKETREE WAY  |       |                               |  |
| LOUISBU   | RG HEALTHCARE & REI                              | HABILITATION CENTER   |                     |   | LOUISBURG, NC 27549  |       |                               |  |
|   |  |   |                     |   | LOUISBURG, NC 27549  |       |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC                                  | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | X                                       | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE    | (X5)<br>COMPLETION<br>DATE    |  |
| F 695   | Continued From page                              | e 13  | F6                  | 695                                     | 5  |       |                               |  |
|   | receive trach care (su                           | uctioning, cleaning, replacing  |                     |   |  |       |                               |  |
|   |  | annula) every shift and as  |                     |   | Med error prevention to include  |       |                               |  |
|   | needed.  | aa.a, e.e., e aa  |                     |   | medication/treatment   |       |                               |  |
|   |  |   |                     |   | administration/documentation and   |       |                               |  |
|   | Resident #1's Medica                             | ation Administration Record   |                     |   | notification/documentation of MD/RP  | of    |                               |  |
|   |  | nd 1-28-22 revealed Resident  |                     |   | refusals or meds/tx's/oxygen or entera   |       |                               |  |
|   | ` '  | rach care as ordered.   |                     |   | feedings not administered.   |       |                               |  |
|   |  |   |                     |   | The DON will ensure that any of the  |       |                               |  |
|   | Nurse #3 was intervie                            |   |                     | above identified staff who does not     |  |       |                               |  |
|   | Nurse #3 acknowledg                              |   |                     | complete the in-service training by     |  |       |                               |  |
|   | for Resident #1 on th                            | e 3:00pm to 11:00pm shift   |                     |   | 2/18/2022 will not be allowed to work  | until |                               |  |
|   | on 1-27-22. The nurse stated he had not provided |   |                     |   | the training is completed. This in-serv  | ce    |                               |  |
|   | Resident #1 with trach care on 1-27-22 and he    |   |                     |   | will be incorporated into the new  |       |                               |  |
|   | said, "I was not made aware the resident needed  |   |                     |   | employee facility orientation.   |       |                               |  |
|   | trach care completed                             | ." Nurse #3 also  |                     |   | The Director of Nurses will complete   |       |                               |  |
|   | _  | was an order for trach care   |                     |   | education of all full time, part time, as  |       |                               |  |
|   |  | n shift and as needed but   |                     |   | needed nurses and agency nurses on   |       |                               |  |
|   |  | form trach care for Resident  |                     |   | trach care. The DON will ensure that a   | •     |                               |  |
|   | #1.  |   |                     |   | of the above identified staff who does   | not   |                               |  |
|   |  |   |                     |   | complete the in-service training by  |       |                               |  |
|   |  | vith Nurse #1 on 2-2-22 at  |                     |   | 2/25/2022 will not be allowed to work  |       |                               |  |
|   | -  | cknowledged she was the   |                     |   | the training is completed. This in-serv  | ce    |                               |  |
|   |  | on 1-28-22 on the 7:00am  |                     |   | will be incorporated into the new  |       |                               |  |
|   |  | nurse stated she had not on Resident #1 during her                                |                     |   | <ul><li>employee facility orientation.</li><li>4. Monitoring Procedure to ensure t</li></ul>             | hat   |                               |  |
|   | •  | she was busy during the   |                     |   | the plan of correction is effective and  |       |                               |  |
|   | morning hours and co                             |   |                     | specific deficiency cited remains corre |  |       |                               |  |
|   | •  | #1 left the facility around   |                     |   | and/or in compliance with regulatory   | Cleu  |                               |  |
|   |  | Nurse #1 stated she could   |                     |   | requirements.  |       |                               |  |
|   | •  | dent #1 needed trach care   |                     |   | The Director of Nurses or LPN Suppo  | rt    |                               |  |
|   |  | off the facility on 1-28-22.  |                     |   | Nurse will monitor compliance utilizing  |       |                               |  |
|   | p. 371434 501010 110 10                          | at the identity of 1-20-22.   |                     |   | F695 Quality Assurance Tool by   | , 410 |                               |  |
|   | The facility's Physicia                          | an was interviewed by   |                     |   | completing an audit weekly x 4 then  |       |                               |  |
|   |  | at 5:30pm. The Physician  |                     |   | monthly x 3 months or until resolved.  | Γhe   |                               |  |
|   |  | t1 being high risk and that he  |                     |   | audit will include monitoring of   |       |                               |  |
|   |  | staff to follow Physician   |                     |   | admit/readmit orders for oxygen thera  | ру    |                               |  |
|   | orders and provide tr                            |   |                     |   | delivery and that tracheostomy care is   |       |                               |  |
|   | ,  |   |                     |   | being provided as ordered for residen  |       |                               |  |
|   | The Administrator wa                             | s interviewed on 2-3-22 at  |                     |   | with a tracheostomy. Reports will be   |       |                               |  |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                    | (X2) MULT<br>A. BUILDI | TIPLE CONSTRUCTION ING |  | (X3) DATE SURVEY<br>COMPLETED      |                            |
|--------------------------|---|---|------------------------|------------------------|--|------------------------------------|----------------------------|
|                          |   | 345358  | B. WING                | /ING                   |  | l                                  | 03/2022                    |
| NAME OF P                | ROVIDER OR SUPPLIER   |   |                        | S                      | TREET ADDRESS, CITY, STATE, ZIP CODE   | 1 02/                              | 03/2022                    |
|                          |   |   |                        | 20                     | 02 SMOKETREE WAY   |                                    |                            |
| LOUISBUI                 | RG HEALTHCARE & REI   | HABILITATION CENTER   |                        | L                      | OUISBURG, NC 27549   |                                    |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG     | Х                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  |                                    | (X5)<br>COMPLETION<br>DATE |
| F 695                    | Continued From page   | e 14  | F                      | 695                    |  |                                    |                            |
|                          | 1:20pm. The Adminis<br>trach care was provid<br>incorrectly. She also | trator stated she believed  |                        |                        | presented to the Quality Assurance Committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at weekly Quality Assurance Meeting. The Weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therap Manager, Health Information Manager, Support Nurse and the Dietary Manager The Director of Nurses or LPN Support Nurse will monitor compliance by completing 4 random trach care observation audits weekly x 4 then monthly x 3 months or until resolved. Reports will be presented to the Quality Assurance Committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitor and the ongoing auditing program reviewed at the weekly Quality Assurant Meeting. The weekly QA Meeting is attended by the Administrator, Director Nursing, Minimum Data Set Coordinator Therapy Manager, Health Information Manager, Support Nurse and the Dieta | the e  Dy  er.  tred  nce  of  or, |                            |
| F 760<br>SS=D            | Residents are Free o<br>CFR(s): 483.45(f)(2)                          | f Significant Med Errors  | F                      | 760                    | Manager.   |                                    | 2/18/22                    |
|                          | medication errors.  | ure that its-<br>nts are free of any significant<br>is not met as evidenced           |                        |                        |  |                                    |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---------------------|---|---------------------|---|---|-------------------------------|--|
|   |                     |   |                     |   |   | С                             |  |
|   |                     | 345358  | B. WING _           |   | _   | 02/03/2022                    |  |
| NAME OF P   | ROVIDER OR SUPPLIER | •   | •                   | STREET ADDRESS, CITY, ST.               | ATE, ZIP CODE   |                               |  |
|   |                     |   |                     | 202 SMOKETREE WAY                       |   |                               |  |
| LOUISBU   | RG HEALTHCARE &     | REHABILITATION CENTER   |                     | LOUISBURG, NC 27549                     | •   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICI        | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | ( (EACH CORREC<br>CROSS-REFEREN         | S PLAN OF CORRECTION<br>CTIVE ACTION SHOULD BE<br>NCED TO THE APPROPRIAT<br>DEFICIENCY) | DATE                          |  |
|   |                     |   |                     |   |   |                               |  |
| F 760   | Continued From p    | age 15  | F 7                 | 60                                      |   |                               |  |
|   |                     | review, staff, and resident   |                     |   | ade on this plan of   |                               |  |
|   |                     | ty failed to administer   |                     |   | an admission to and d   | lo                            |  |
|   |                     | cribed to treat residents' pain,  |                     | not constitute an ac                    |   |                               |  |
|   |                     | shortness of breath per   |                     | alleged deficiencies                    |   |                               |  |
|   | 1                   | This occurred for 1 of 1  |                     | -                                       | liance with all federal   |                               |  |
|   | ,                   | ent #1) reviewed for medication   |                     |   | ns the facility has take  | ∍n                            |  |
|   | errors.             |   |                     | or will take the action                 |   |                               |  |
|   | Findings included   |   |                     | constitutes the facil                   | The plan of correction  | 1                             |  |
|   | Findings included   | •   |                     | compliance such th                      |   |                               |  |
|   | Resident #1 was r   | e-admitted to the facility on   |                     | · ·                                     | nave been or will be  |                               |  |
|   |                     | ple diagnoses that included   |                     | corrected by the da                     |   |                               |  |
|   |                     | upplemental oxygen, COVID-19,   |                     | F760                                    | noo maloatoa.   |                               |  |
|   |                     | nxiety, atypical psychosis.   |                     | The plan of correct                     | ing the specific  |                               |  |
|   | •                   | 3, 31 1 3   |                     |   | n should address the  |                               |  |
|   | The quarterly Mini  | imum Data Set (MDS) dated   |                     | processes that lead                     |   |                               |  |
|   | 11-12-21 revealed   | Resident #1 was cognitively   |                     | cited:                                  |   |                               |  |
|   | intact.             |   |                     | The facility failed to                  | administer ordered  |                               |  |
|   |                     |   |                     |   | in, hypotension and   |                               |  |
|   |                     | e record dated 1-27-22 was  |                     | shortness of breath                     |   |                               |  |
|   |                     | ealed Resident #1 was   |                     | Corrective acti                         |   |                               |  |
|   | _                   | o the facility at 1:30pm on   |                     |   | ged deficient practice  |                               |  |
|   | 1-27-22.            |   |                     |   | sent to the emergency   | ′                             |  |
|   | The physician and   | are dated 4 07 00 revealed the  |                     |   | 2 and admitted to the   |                               |  |
|   |                     | ers dated 1-27-22 revealed the  |                     | hospital.                               | ion for residents with  |                               |  |
|   | •                   | on orders; Midodrine  |                     |   | affected by the allege  |                               |  |
|   |                     | 2.5mg three times a day,<br>er solution) 0.5/2.5mg/3ml  |                     |   | anected by the allege   | u                             |  |
|   |                     | hours, Gabapentin (pain   |                     | deficient practice.                     |   |                               |  |
|   | medication) 300m    |   |                     | All residents have t                    | the potential to be   |                               |  |
|   | modication, coom    | g mgmay.  |                     |   | ged deficient practice  | <u>.</u>                      |  |
|   | Review of Reside    | nt #1's Medication  |                     |   | e Director of Nurses,   |                               |  |
|   |                     | cord (MAR) for 1-27-22 on the   |                     |   | N) initiated an audit o   | f                             |  |
|   |                     | m shift revealed Resident #1 did  |                     | ''                                      | ation Administration fo   |                               |  |
|   |                     | lowing medications: Gabapentin  |                     | the last 14 days for                    | r all current residents.  |                               |  |
|   | 300mg at bedtime    | , Midodrine 2.5mg three times   |                     | The audit consisted                     | d of a review of the  |                               |  |
|   | a day, DuoNeb 0.    | 5/2.5mg/3ml every 6 hours.  |                     | Electronic Medical                      | Administration Record   | ds                            |  |
|   |                     |   |                     |   | lentify any medication  |                               |  |
|   | Resident #1's MA    | R for the morning of 1-28-22  |                     | that were omitted o                     | or not administered du  | ıe                            |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            |   | L IDENTIFICATION NUMBER:  |                    | (2) MULTIPLE CONSTRUCTION  . BUILDING |  |         | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|---|--------------------|---------------------------------------|--|---------|-------------------------------|--|
|  |   | 345358  | B. WING _          |                                       |  |         | C<br><b>/03/2022</b>          |  |
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP |   |   |                    | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 02/  | 03/2022 |                               |  |
|  |   |   |                    |                                       | 202 SMOKETREE WAY  |         |                               |  |
| LOUISBUI   | RG HEALTHCARE & REI                           | HABILITATION CENTER   |                    |                                       | OUISBURG, NC 27549   |         |                               |  |
| 240.1=   | CLIMMA DV CT                                  | ATEMENT OF DEFICIENCIES   |                    |                                       | ,<br>T   |         | (X5)                          |  |
| (X4) ID<br>PREFIX<br>TAG                                       | (EACH DEFICIENC                               | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG |                                       | PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)   |         |                               |  |
| F 760  | Continued From page                           | e 16  | F                  | 760                                   |  |         |                               |  |
|  |   | provided the following<br>ne 2.5mg three times a day,<br>ml every 6 hours.      |                    |                                       | to not being available for any reason. I audit identified 0 residents who had medications that were not administered All medications were found to be available. | d.      |                               |  |
|  | Resident #1 was intel 2-2-22 at 11:28am. H    | rviewed by telephone on<br>e discussed being                                    |                    |                                       | on the carts.  |         |                               |  |
|  | re-admitted to the fac                        | ility on 1-27-22 in the   |                    |                                       | 3. Measures /Systemic changes to   |         |                               |  |
|  | afternoon. Resident #                         |   |                    |                                       | prevent reoccurrence of alleged deficie  | nt      |                               |  |
|  | provided any of his m<br>1-27-22 and only som |   |                    | practice:                             |  |         |                               |  |
|  | morning of 1-28-22.                           |   |                    |                                       | Beginning on 02/03/2022, the facility si<br>were also educated to contact the Dire   |         |                               |  |
|  | Nurse #3 was intervie                         |   |                    | of Nurses or the on-call nurse to     |  |         |                               |  |
|  |   | was assigned to Resident  |                    |                                       | communicate any obstacles that would   | Í       |                               |  |
|  | #1 on the 3:00pm to                           | 11:00pm shift on 1-27-22.   |                    |                                       | prevent the staff from being able to   |         |                               |  |
|  | The nurse stated he h                         | nad not provided Resident   |                    |                                       | administer medications as ordered. The   | ıe      |                               |  |
|  |   | ening medications, and he   |                    |                                       | Director of Nurses or designee will add  | l       |                               |  |
|  | stated, "I could not fir                      | nd his medications to   |                    |                                       | review of the EMAR progress notes to   |         |                               |  |
|  |   | d he had found Resident   |                    |                                       | their daily checklist to identify any  |         |                               |  |
|  |   | ne end of his shift around  |                    |                                       | residents who did not have medication  | s       |                               |  |
|  | 11:00pm but still did r medications to Reside |   |                    |                                       | available for administration.  |         |                               |  |
|  |   |   |                    |                                       | On 02/03/2022, the Director of Nurses  |         |                               |  |
|  | Nurse #1 was intervie                         | ewed on 2-2-22 at 12:20pm.  |                    |                                       | initiated education on Medication  |         |                               |  |
|  | The nurse acknowledged she was assigned to    |   |                    |                                       | Availability for all Licensed Nurses (RN   | l□s     |                               |  |
|  | care for Resident #1                          | on 1-28-22 from 7:00am to   |                    |                                       | and LPN□s), Medication Aides, Full Tir   | ne,     |                               |  |
|  | 3:00pm. Nurse #1 sta                          | ited she had provided   |                    |                                       | Part Time, PRN, and Agency Nurses o  | n       |                               |  |
|  | Resident #1 with the                          | medications that were   |                    |                                       | the following education:   |         |                               |  |
|  | available. She stated                         | some medications were on  |                    |                                       |  |         |                               |  |
|  | order from the pharm                          | acy.  |                    |                                       | "The learner will understand the   |         |                               |  |
|  |   |   |                    |                                       | importance of ensuring that medication   |         |                               |  |
|  |   | s interviewed on 2-3-22 at  |                    |                                       | are always available to be given to the  |         |                               |  |
|  |   | ed Resident #1's medication   |                    |                                       | resident as ordered by the Physician.  |         |                               |  |
|  |   | is return from the hospital on  |                    |                                       | "The learner will understand the steps   |         |                               |  |
|  |   | now why the medications   |                    |                                       | necessary to obtain medications from t   | .he     |                               |  |
|  |   | ne Administrator also stated  |                    |                                       | McNeill ☐s Long-Term Care Pharmacy   |         |                               |  |
|  |   | ere the system breakdown  |                    |                                       | during business hours and after busine   | SS      |                               |  |
|  | occurred.                                     |   |                    |                                       | hours for all situations.  |         |                               |  |
|  |   |   |                    |                                       | "The learner will understand the   |         |                               |  |

|  |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' '              | (2) MULTIPLE CONSTRUCTION . BUILDING |   |  | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|--------------------|--------------------------------------|---|--|-------------------------------|--|
|  |  | 345358   | B. WING _          |                                      |   |  | 03/2022                       |  |
| NAME OF P                                    | ROVIDER OR SUPPLIER  | 1  |                    | STF                                  | REET ADDRESS, CITY, STATE, ZIP CODE   | 1 021                                  | 03/2022                       |  |
|  |  |  |                    | 202                                  | 2 SMOKETREE WAY   |  |                               |  |
| LOUISBURG HEALTHCARE & REHABILITATION CENTER |  |  |                    | LO                                   | DUISBURG, NC 27549  |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                     | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |  | ID<br>PREFI<br>TAG | x                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE    |  |
| F 760  | Continued From page  | e 17   | F                  | 760                                  | importance of administering ordered medications to prevent delay in tx, uncontrolled pain or a change in condit "Reordering needed medications for the med dispense if needed.  All education for current staff will be completed by 02/18/2022. As of 02/18/2022, any employee who has no received this training will not be allowed work until the training has been completed. This includes all Licensed Nurses and Medication Aides, full time, part time, agency staff, and PRN staff. This in-service will be incorporated into the new employee facility orientation.  4. Monitoring Procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements.  The Director of Nurses or LPN Support Nurse will monitor compliance utilizing F760 Quality Assurance Tool by completing an audit weekly x 4 then monthly x 3 months or until resolved. The audit will include review of the EMAR progress notes to identify any residents who have medications that have not be administered related to any obstacle the would prevent the staff from being able administer medications as ordered. Reports will be presented to the Quality Assurance Committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored. | e  t d to  at hat bted  the seen at to |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | IDENTIFICATION NUMBER. |           | PLE CONSTRUCTION  G  |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|------------------------|-----------|--|--|-------------------------------|--|
|   |   | 345358                 |           | B. WING  |  | С                             |  |
|   |   | 345356                 | B. WING _ |  |  | 02/03/2022                    |  |
| NAME OF P   | NAME OF PROVIDER OR SUPPLIER  |                        |           | STREET ADDRESS, CITY, STATE, ZIP CODE  |  |                               |  |
| LOUISBU   | LOUISBURG HEALTHCARE & REHABILITATION CENTER  |                        |           | 202 SMOKETREE WAY  |  |                               |  |
|   |   |                        |           | LOUISBURG, NC 27549  |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  BY THE PROVIDER'S PLAN OF CORRECTION  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADE DEFICIENCY) |                        | HOULD BE  | (X5)<br>COMPLETION<br>DATE   |  |                               |  |
| F 760   | Continued From page   | ± 18                   | F 7       | and the ongoing auditing prograreviewed at the weekly Quality Meeting. The weekly QA Meeting attended by the Administrator, I Nursing, Minimum Data Set Coo Therapy Manager, Health Inform Manager, Support Nurse and the Manager. | Assurance and is solution of control or cont |                               |  |